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Medicaid in-home services programs Department of Public Health and Human Services

Legislative Audit Division

State of Montana

Report to the Legislature

December 1998

Performance Audit

Medicaid In-Home Services Programs

Department of Public Health and Human Services

This report contains recommendations addressing controls over three primary Medicaid In-Home Services Programs: the Home Health Program, the Personal Assistance Services Program, and the Home and Community Based Services Program. The recommendations for each program include:

Home Health Program

- **Establishing a provider compliance review process.**
- **Developing a provider education program.**

Personal Assistance Services Program

- **Establishing methods to review personal assistance service weekly limits.**
- **Establishing procedures to determine if providers meet standards.**

Home and Community Based Services Program

- **Transferring appropriation authority for recipients on the waiting list.**
- **Including review of home visit documentation.**

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Members of the performance audit staff hold degrees in disciplines appropriate to the audit process. Areas of expertise include business and public administration, statistics, economics, computer science, and engineering.

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December 1998

The Legislative Audit Committee
of the Montana State Legislature:

This is our performance audit of the Department of Public Health and Human Services' Medicaid In-Home Services Programs: the Home Health Program, the Personal Assistance Services Program, and the Home and Community Based Waiver Program.

This report contains recommendations concerning establishing a provider compliance review process, developing provider education programs, and using statistical tools and extrapolation for sampling Medicaid provider payments. The department's written response to audit recommendations is included in the back of the report.

We thank the director and department personnel for their cooperation and assistance throughout the audit.

Respectfully submitted,

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Legislative Auditor

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Legislative Audit Division

Performance Audit

Medicaid In-Home Services Programs

Department of Public Health and Human Services

Members of the audit staff involved in this audit were Kris Wilkinson and Mary Zednick.

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Department of Public Health and Human Services	Laurie Ekanger, Director
	Mike Hanshew, Administrator, Senior Long Term Care Division
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	Joe Mathews, Administrator, Disability Services Division
	Joyce DeCunzo, Chief, Community Services Bureau

Introduction

We conducted a performance audit of the Medicaid Home Health, Personal Assistance Services, and Home and Community Based Services Programs, administered by the Community Services Bureau at the Department of Public Health and Human Services. The three programs provide the majority of publicly funded in-home health services.

-- Home Health Program - skilled nursing services, physical therapy, speech therapy, and occupational therapy.

-- Personal Assistance Services Program - help with activities of daily living such as dressing and grooming, household tasks, and escort services.

-- Home and Community Based Services Program - an array of services including case management, traumatic brain injury services, and private duty nursing.

The Legislative Audit Committee requested a performance audit of the Home Health Program as part of the Medicaid Partnership Plan.

Audit Objectives

The objectives of our performance audit were to:

1. Determine the adequacy of procedures and controls over Medicaid payments to providers for home health, personal assistance, and home and community based services.

2. Determine if the Community Services Bureau is in compliance with applicable state and federal laws and regulations pertaining to the three programs.

Based on our audit work the control structure over home health payments is not adequate to ensure providers follow program requirements. Our review also showed controls are adequate to ensure providers comply with program requirements of the Personal Assistance Services Program and the Home and Community Based Services Program. Our recommendations in these programs address improvements for these procedures.

Report Summary

Disclosure Issue Regarding Federal Surety Bonding Requirements

Congress recently passed legislation requiring home health agencies providing federal Medicare or Medicaid services to obtain a minimum $50,000 surety bond for each program. During fiscal year 1997-98, total Montana Medicaid expenditures for home health services were approximately $1,600,000. Bonding requirements, as currently proposed, require Montana Medicaid home health providers obtain a total of approximately $2,200,000 in surety bonds, an amount exceeding total program expenditures by over 37 percent. If the policy does not change there is a possibility some Montana Medicaid home health services providers will no longer participate in the program as the total amount of the bond will exceed the providers' revenues generated by Medicaid for home health services. This could cause service delivery issues in some areas in the state.

Home Health Expenditures Reduced

The Community Services Bureau implemented a number of controls to reduce home health expenditures. The controls included a fixed fee payment for home health visits, limits of 75 skilled nursing services a year and a combined maximum of 100 visits a year for other home health services, confirming growth rates were within legislatively mandated rates before implementing provider rate increases, and reviewing services provided to high cost recipients to determine if cost-effective alternatives existed. The culmination of the changes resulted in a reduction of $1.4 million in expenditures from fiscal year 1995-96 to fiscal year 1997-98. The changes also reduced the number of recipients receiving home health services by 447 and reduced the average annual cost of home health services per recipient by $473.

Controls Over Home Health Services Could be Improved

Based on our audit work, we determined the control structure over home health expenditures is not functioning in such a way as to ensure providers comply with federal and state requirements. The bureau could improve controls over the Home Health Program by:

1. Ensuring home health care givers receive program policies and procedures manuals.
2. Implementing a compliance review process for home health providers.
3. Developing a provider education program for home health providers.

4. Developing policies and procedures for physician's approval of plans of care.

Bureau staff negotiated a contract with a private company to conduct yearly reviews of home health providers which will include determining if the services provided were medically necessary. Bureau staff are also developing a provider education program and staff are in the process of developing a policy manual which should be completed and released in December 1998.

Cost Efficiency Measures Which Can Reduce Medicaid Costs

Federal Medicaid requirements include providing Medicaid services in the most efficient and cost-effective manner possible. During our review of home health payments, we identified three cost-effectiveness measures related to home health services.

-- The bureau should consider developing a cost per unit of service reimbursement for home health payments rather then the current fixed service fee of $60.43 per visit.

-- The bureau should implement more cost-effective methods for delivering medications, including insulin.

-- The bureau and the Developmentally Disabled Program need to develop a cost-effective method of delivering home health nursing services to developmentally disabled recipients using current care alternatives such as private duty nursing.

Controls Over Personal Assistance Services Could be Improved

The Personal Assistance Services Program allows a recipient to receive up to 40 hours of personal assistance services a week. Personal assistance hours can be provided in excess of this amount with written department approval. We determined providers in our sample were paid for services in excess of weekly limits without prior authorization from the bureau.

Controls over the program could be improved if the bureau:

1. Required providers to submit claims for personal assistance services covering a week time period.
2. Established an edit in the Montana Medicaid Information System which would identify billing submitted in excess of the weekly limits for personal assistance services.

3. Included a review of personal assistance claims during provider compliance reviews to ensure providers do not bill for overlapping weeks.

Self-Directed Health Maintenance Elections

Recipients of personal assistance services can participate in the Self-Directed Assistance Services Program. The recipient hires, directs, and fires his/her employees. Included in the program is the option of having the personal attendant provide health maintenance tasks. We found three recipients in our sample elected to have their personal attendant perform health maintenance tasks but had a home health agency perform the tasks when their medical condition changed. This resulted in the Medicaid program paying for the health maintenance tasks of these clients twice, once through the Self-Directed Assistance Services Program and once through the Home Health Program.

By providing Medicaid self-directed personal assistance service recipients clarification and education relating to amendments of plans of care if their condition changes, and including review of both self-directed assistance services and home health services provided to recipients during compliance reviews, the bureau could improve controls.

Compliance Reviews Not Consistent

Regional program officers perform annual compliance reviews of all personal assistance providers. During testing of compliance reviews, we found the final determination of whether providers meet the standard, meet the standard with comments from the bureau, or did not meet the standard did not always agree with the information gathered from the chart reviews. To improve this process we recommend the bureau establish procedures to ensure the determination of whether a personal assistance provider meets standards is based on the results of the charts reviewed.

Home Visit Information Not Consistent

Regional program officers did not consistently gather the same type of information from recipients during visits to the recipients' residences. Implementing a home visit process which ensures regional program officers obtain the same information when conducting the reviews and ensuring regional program officers retain records of home visits will help ensure consistent information is gathered during home visits. Periodically, reviewing worksheets used in provider compliance reviews

to determine if officers have followed bureau procedures relating to home visits could also help the bureau ensure consistency.

The Community Services Bureau concurs with our recommendations for improvements over the Personal Assistance Services Program and has taken steps to improve the controls.

Controls Over Home and Community Based Services Program Could be Improved

During our review of the home and community based (waiver) services, we identified several issues pertaining to controls over waiver services. These issues relate to the home and community based services waiting list, home visits made by case management teams and rules for services for recipients with traumatic brain injuries.

Waiting List

We reviewed the waiting list for waiver services, including types of services required and current residence of recipients. We found 72 recipients require adult residential services. Twenty-one of the 72 recipients reside in nursing homes. The Medicaid program could save between $74,964 and $196,761 by providing adult residential services under the waiver program for these 21 eligible recipients. The Medicaid program could save additional funds by appropriately placing the other 51 recipients needing adult residential services prior to their entering a nursing home. If the legislature includes language to emphasize that the department can transfer appropriation authority between Medicaid programs, the department could then transfer Medicaid funds into the home and community base services program to reduce nursing home expenditures.

Home Visits

Bureau policy and procedures require case management teams evaluate the medical stability, mobility, independence, judgement or cognitive impairment, and adequacy of current placements for recipients identified as needing waiver services and placed on the waiting list. We determined some teams were not making home visits to all recipients on the waiting list to assess the recipients' conditions and to prioritize their need for services. Since the bureau staff did not include home visit documentation in their compliance reviews of contracted case management teams, they were unaware not all teams were making home visits. The bureau should include home visit documentation in the

compliance review process of home and community based services providers.

Traumatic Brain Injury Service Rules

The bureau does not have rules relating to traumatic brain injury services provided under the waiver program. Implementing rules for traumatic brain injury services provided under the Home and Community Based Services Program ensures all providers meet the same criteria for providing these services.

Other Administrative Issues

The bureau uses a compliance review process as a control to ensure providers comply with program requirements. Overpayment recoveries are based on errors found in a two-week billing span rather than a statistical sample of services provided during the entire year. By developing a statistical sampling approach to identify individual in-home service provider's overpayments for the year under review the bureau ensures providers return all overpayments.

We reviewed Medicaid copayment amounts for home health services and medical supplies provided to recipients in our home health sample. We found the medical supply payment calculation does not include determining the number of services provided when determining the copayment amount. Durable medical supplies can be provided by hospitals, physicians, home health agencies, and other Medicaid providers. The incorrect calculations are made on all durable medical and medical supply claims. The department should ensure the computer calculation and Medicaid publications for copayments are in compliance with section 41.12.204., ARM.

Chapter I - Introduction

Introduction

Montana Medicaid recipients receive care in their homes for health needs resulting from diseases such as multiple sclerosis, cerebral palsy, chronic obstructive pulmonary disease, or congestive heart failure. Three programs provide the majority of publicly funded in-home health services.

> Home Health Program - skilled nursing services, physical therapy, speech therapy and occupational therapy.
> Personal Assistance Services Program - help with activities of daily living such as dressing and grooming, household tasks, and escort services.
> Home and Community Based Services Program - an array of services including case management, traumatic brain injury services, and private duty nursing.

Recipients can receive services from one program or a combination of services from the three programs. The programs are administered by the Community Services Bureau, Department of Public Health and Human Services.

We conducted a performance audit of the three programs. The Legislative Audit Committee initially requested a performance audit of the Home Health Program as part of the Medicaid Partnership Plan. The Partnership Plan outlines suggested joint federal and state audits of Medicaid programs which have saved money in other states. Due to the amount of expenditures made for other in-home services, we expanded the scope of our audit to include personal assistance services and home and community based services. We conducted this audit in cooperation with federal auditors who provided technical support. The In-Home Services Programs audit is the first partnership audit conducted on Medicaid home health services in the country. Copies of this report are transmitted to the federal Department of Health and Human Services, Office of the Inspector General. The Inspector General transmits the report to the administrator of the federal Health Care Financing Administration (HCFA).

Chapter I - Introduction

Audit Objectives

The objectives of our performance audit were to:

1. Determine the adequacy of procedures and controls over Medicaid payments to providers for home health, personal assistance, and home and community based services.

2. Determine if the Community Services Bureau is in compliance with applicable state and federal laws and regulations pertaining to the three programs.

Scope and Methodology

The audit was conducted in accordance with governmental auditing standards for performance audits. As required by performance audit standards, we included noteworthy management accomplishments in the report. We reviewed state and federal statutes relating to the three Medicaid programs. We reviewed a statistical sample of 113 home health claims for services provided in November and December 1997, and paid in January 1998. The claims were for 106 Medicaid recipients. We determined if providers met billing requirements for services for the three programs. Audit work was done both centrally (Helena) and throughout the state.

As part of the testing, we traveled with the bureau chief and program manager who provided technical support. We visited 23 of 55 home health providers throughout Montana to review home health service recipient charts. We compared information on recipient charts to billing information submitted by the providers. We did not determine the medical necessity of the treatment provided by home health providers.

Recipient profiles listing all Medicaid services billed for November or December 1997 were reviewed. Program requirements for personal assistance services and home and community based services were tested for services listed on recipient profiles. The profiles were also reviewed for duplicated services and billing errors.

We interviewed a sample of Medicaid home health service recipients in their homes to confirm program participation and types of services received. We sent a client survey to the sample of 106 Medicaid recipients to determine if they received the services the program paid for on their behalf.

We gathered information on program expenditures and examined program services for cost savings methodologies. We contacted the Montana Association of Home Health Agencies and spoke to their membership about the audit. We reviewed the impact of new federal surety bonding requirements on home health providers and recipients.

We reviewed the bureau's compliance review process for Personal Assistance Services and the Home and Community Based Waiver Programs to determine if controls over the programs ensure providers comply with program requirements. Interviews were conducted with regional program officers and case management teams discussing procedures used to complete compliance reviews and recipient home visits. We reviewed case management providers' recipient charts to ensure providers followed program standards. Provider training was observed to determine bureau procedures for provider education. Provider compliance review reports completed in the last two years were reviewed for patterns of noncompliance. Policy and procedure manuals for both programs were reviewed to ensure inclusion of federal and state requirements.

We reviewed bureau procedures for placing recipients on waiting lists to receive services from the Home and Community Based Services Program. The Home and Community Based Services Program also provides services for traumatic brain injured clients. We conducted a review of traumatic brain injured services at the facilities providing these services. We observed recipient treatment and interviewed program personnel.

The Community Services Bureau also administers the Medicaid Hospice and Home Dialysis Programs. We did not include the Home Dialysis Program in the scope of this audit since the program did not serve any Medicaid recipients in fiscal year 1997-98. The Hospice Program manager completes a review of approximately 60 percent of expenditures to ensure providers follow program requirements. The review procedures for the Hospice Program were implemented following a federal review of the program. We did not include the Hospice Program in the scope of this audit because of this recent federal review.

Compliance

We examined compliance with statutes and administrative rules for in-home service program activities. We found the Community Services Bureau generally in compliance with regulatory requirements. We address the need for administrative rules for traumatic brain injury services in Chapter V.

Investigation of Possible Fraudulent Billing

During our testing, we noted billing patterns in provider claims which suggests the possibility of fraud. Under the provisions of section 5-13-304(4), MCA, we referred this matter to the Attorney General and the Governor. The Attorney General is investigating.

Areas for Future Study

We noted three areas we believe should be studied further. The areas include workload in the Surveillance and Utilization Review Section, an electronic data processing audit of the Medicaid Management Information System, and controls over Medicaid pharmacy and physician services providers. These issues are discussed in greater detail in the following sections.

SURS

The Surveillance and Utilization Review Section (SURS) of the Quality Assurance Division evaluates the appropriateness of claims paid under the Medicaid program. It identifies concerns through review of randomly selected claims and exception reports. Once a concern is identified, section staff run a claims listing by provider. Based on a review of the listing, section staff determine if a full investigation of the provider is warranted.

When a concern relating to a provider has been identified, a case on the provider is opened. In January 1998, section staff indicated they had approximately 200 open cases. One case was opened for review in June 1996 and still had not been investigated. On September 10, 1998, the unit had 268 cases open.

Based on the number of cases the section has under review, the length of time between when a case is opened and when the review is completed, and the increase in the number of cases in the first nine months of 1998, we believe an audit of SURS is warranted. Potential scope of an audit could include a review of prioritization methods, staff workloads, and the need for additional resources.

Medicaid Management Information System

In the Medicaid Clinical Laboratory Service Payment Audit (97P-02), we recommended an audit of the Medicaid Management Information System (MMIS). During the current audit, we identified a concern relating to provider billing on the HCFA 1500 form. Personal assistance service providers, case management providers, physicians, and independent laboratories bill for Medicaid services using the HCFA 1500 form. We found providers received payment for services billed in excess of the daily limit for case management services. Case management services are limited to a single service in a day. One provider was paid for 54 units of service in a single day for a total of $425. Based on the number of provider types using the HCFA 1500 form to bill for Medicaid services, we recommend the MMIS audit include review of the HCFA 1500 form and daily service requirements.

We also found inappropriate payments of $462 made for duplicate billings on a UB-92 form. The provider submitted claims for physical therapy services twice on the same claim form. Providers using the UB-92 forms include hospitals, residential treatment facilities, free standing dialysis facilities, hospice, and rural health clinics. Based on the number of providers using the UB-92 form to bill for Medicaid services, we recommend the MMIS audit also include a review of duplicate payment controls for the UB-92 form.

Controls Over Medicaid Pharmacy and Physician Services Providers

During testing of home health services, we determined the Medicaid Pharmacy Program overpaid a provider $150,186 for a drug which was incorrectly billed. We determined a physician billed the Medicaid program for services which were provided by a home health agency. We also found numerous problems with Medicaid recipient charts. The Department of Public Health and Human Services is responsible for ensuring over 6,000 providers follow policies and procedures when they file claims under various Medicaid programs. Many providers submit claims under multiple programs. For example, hospitals submit inpatient, outpatient, pharmacy, durable medical supplies, and clinical laboratory billings for Medicaid eligible recipients.

Based on the concerns with other Medicaid programs found in this audit, we recommend continuation of partnership audits of other Medicaid programs. Potential scope could include review of controls

over other Medicaid programs including provider compliance with program requirements.

Management Memorandums

During the course of the current review, we discussed several issues with the department. These issues are not the subject of recommendations in this report but were sent to the department as management memorandums. One issue related to the need to improve documentation of compliance reviews conducted of Medicaid personal attendant service providers. The memorandum addressed a regional program officer's failure to maintain documentation of records reviewed during compliance reviews.

Another memorandum addressed controls over home and community based services relating to the use of chore services. Chore services or heavy cleaning services are provided to waiver recipients when cleanliness of their current residence endangers their health. The memorandum addressed a misunderstanding by a case management provider regarding the appropriate use of chore services.

We also addressed a concern regarding how often treatment plans for Medicaid home health recipients are reviewed and renewed by physicians. Medicare guidelines require treatment plan renewal every 62 days, where as Medicaid guidelines require renewal every 60 days. Providers use computerized programs which follow Medicare guidelines. As a result, 91 of 106 recipient charts tested during our audit did not have treatment plans reviewed every 60 days as required by federal program guidelines. We discussed the issue with the HCFA regional officer for Montana suggesting a standardized guideline of 62 days for both programs. The HCFA officer was unaware of the different renewal periods for the two federal programs. The officer stated HCFA would be willing to issue the Montana Medicaid Home Health Program a policy decision allowing Medicaid home health services to follow Medicare home health requirements for renewal of recipient treatment plans. The Community Services Bureau staff requested a formal policy decision from HCFA on this issue. The HCFA officer formally notified the bureau of another federal guideline allowing the use of 62-day renewal periods for the Medicaid program.

The officer stated they will bring the discrepancy between the two guidelines to the attention of the central office.

Disclosure Issue Regarding Federal Surety Bonding Requirements

As part of home health services, we reviewed the impact new federal surety bonding requirements will have on Montana Medicaid home health providers. The requirements have been suspended until February 1999. However, during our review, we identified a concern with federal surety bond requirements as discussed below.

Audits of the Medicare Program Conducted

The Office of the Inspector General for the Department of Health and Human Services conducted audits of home health agencies participating in the Medicare program. These audits were performed as part of the federal-initiated "Operation Restore Trust." The audits were conducted to determine whether payments to home health agencies met Medicare reimbursement requirements. The audits were performed in five states and included ten home health agencies. The financial impact of the reviews could total as much as $65 million in repayments by the audited providers.

The reviews showed claims were ineligible for Medicare reimbursement because: 1) recipients did not require skilled nursing services or physical or speech therapy; 2) recipients were not homebound; 3) some services were medically unnecessary, excessive, or not supported by documentation in the medical records; and 4) some services were either not provided or were provided less frequently than actually claimed.

Congress Passed Federal Legislation Requiring Surety Bonds

Due to the seriousness of the problems found in the audits, Congress passed federal legislation requiring home health providers participating in Medicare and Medicaid programs to purchase surety bonds. The requirement was enacted, in part, to ensure the HCFA had a mechanism which ensured providers would be able to make payments to HCFA if the providers had received ineligible reimbursements.

HCFA attempted to implement the statute requiring home health agencies providing Medicare and/or Medicaid services post a minimum $50,000 surety bond for each program in February 1998. Due to numerous issues with the surety bonds, including providers inability to

obtain them, HCFA delayed the implementation of the surety bond requirement until no earlier than February 15, 1999.

Montana Providers Required to Bond in Amounts Exceeding Entire Medicaid Home Health Program Expenditures

In fiscal year 1997-98, total Montana Medicaid expenditures for home health services were approximately $1,600,000. Bonding requirements, as currently proposed, require Montana home health providers provide a total of approximately $2,200,000 in surety bonds, an amount exceeding total program expenditures by over 37 percent.

The Department of Public Health and Human Services notified HCFA of this issue in a letter March 4, 1998. According to Community Services Bureau personal, HCFA staff stated they will change the policy allowing providers receiving less than a specified amount in Medicaid funds to obtain a single surety bond for Medicare and Medicaid. If the policy does not change there is a possibility some Montana Medicaid home health services providers will no longer participate in the program since the total amount of the bond will exceed the providers' revenues generated by Medicaid for home health services. This could cause service delivery issues in some areas of the state.

Report Organization

This report is presented in six chapters.

Chapter I - Introduction and Scope of Work
Chapter II - Background
Chapter III - Home Health Program
Chapter IV - Personal Assistance Services Program
Chapter V - Home and Community Based Services Program
Chapter VI - Other Administrative Issues

Chapter II - Background

Introduction

The Montana Medicaid program is administered by the Department of Public Health and Human Services. The Medicaid program (CFDA 93.778), administered under federal regulations, serves qualifying recipients. Medicaid is jointly funded by the federal and state governments and is considered an entitlement program. Entitlements are services which must be provided to any eligible recipient. As an entitlement program, there is no limit or cap on federal outlays for the Medicaid program. The federal government provides matching funds for whatever the state spends on its Medicaid program. Therefore, in Montana, a limiting factor on Medicaid services is the level of state funds allocated and expended for that purpose.

Medicaid funding includes General Funds, and state and federal Special Revenue Funds. Approximately 70 percent of the Montana Medicaid Program expenditures are federally funded. The state provides the remaining 30 percent as a match to the federal funds. The legislature allocated approximately $236 million of state funds (comprised of $219 million General Fund and $17 million State Special Revenue) in the 1999 biennium for Medicaid medical benefits, an approximate 7.5 percent increase from the 1997 biennium. State funds were matched with approximately $602 million of federal Medicaid funds. The state Special Revenue Fund is property tax revenue from the 12 state-assumed counties, nursing home bed taxes, and donations. County funds supply part of the state match for primary care Medicaid benefits.

In setting the state fund allocation for Medicaid, the 1997 Legislature stated its opposition to unrestricted growth in the Medicaid program. The legislature added language to House Bill 2 directing the department to not exceed specific general funded Medicaid growth rates in the 1999 biennium (5.25 percent in fiscal year 1997-98 and 3.0 percent in fiscal year 1998-99). The legislature also directed the department to implement section 53-6-101(11), MCA, to limit, reduce, or otherwise curtail the amount, scope, or duration of medical services if available funds are not sufficient.

Community Services Bureau

The Community Services Bureau (the bureau) of the Senior and Long Term Care Division administers the Medicaid Home Health, Personal Assistance Services, and Home and Community Based Services Programs. The bureau's mission is to address the needs of Medicaid eligible Montanans who require assistance and support in meeting their ongoing health needs. Bureau staff stated the programs meet the needs by developing, managing, and funding home-based care, which fosters independence, contains costs, and provides options to consumers.

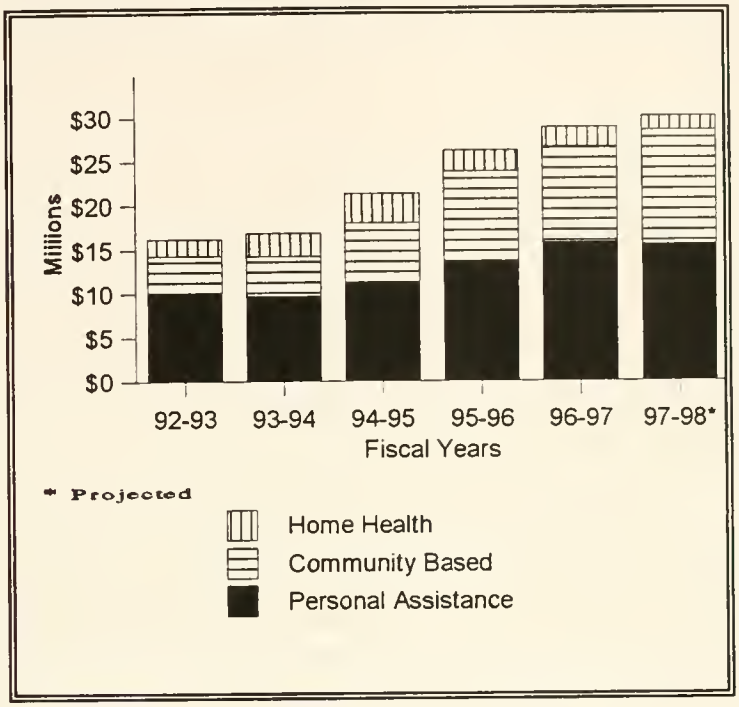
The Montana Medicaid Program was established in 1967. With its inception in Montana, only basic services were offered by Medicaid: hospitalization, physician services, skilled nursing care in the recipient's home, prescription drugs, and dental services. Services provided in the recipient's home were included as a measure to reduce Medicaid costs by shortening the length of hospital stays and reducing the number of recipients placed in nursing homes. Personal assistance services and home and community based services were added as services in 1978 and 1983, respectively. The three programs are designed to reduce nursing home costs by allowing recipients to receive needed services in their homes.

Program Costs

Total In-Home Services Program expenditures in fiscal year 1995-96 were $26.5 million. In fiscal year 1995-96, 1,445 recipients received Montana Medicaid home health services at a cost of approximately $3 million. In the same year, 2,632 Medicaid recipients received personal assistance services at a cost of approximately $13 million. There were approximately 1,200 persons served by the Home and Community Based Services Program in fiscal year 1995-96 at a cost of approximately $10.5 million. The legislature authorized an additional $2.1 million in fiscal year 1997-98 and $2.5 million in fiscal year 1998-99 to expand the community based program and provide services to a minimum of 72 people on a waiting list for community based services.

Home Health Services Program, Personal Assistance Services Program, and Home and Community Based Services Program costs are presented in Figure 1.

Figure 1
Medicaid In-Home Services Program Costs
(Fiscal Years 1992-93 through 1997-98)



Source: Compiled by the LAD from bureau statistics.

Home health costs declined between fiscal years 1994-95 and 1996-97, while personal assistance and community based costs increased. We discuss the reasons for these increases and decreases in the following section.

Home Health Program Expenditures Reduced

In fiscal year 1993-94, 936 recipients received home health services at a cost of $1.9 million. This resulted in average annual expenditures of $2,029 per recipient. In fiscal year 1995-96, 1,445 recipients received Medicaid home health services at a total cost of approximately $3 million or an average annual cost of $2,076 per recipient. This represents a 58 percent increase in home health expenditures in two

years. However, this also represents only a 2.3 percent increase in expenditures per recipient.

In response to legislation restricting Medicaid expenditure growth, the bureau implemented a number of controls to reduce home health expenditures. In fiscal year 1996-97, the bureau implemented a fixed reimbursement fee for home health providers as one method to reduce growth. Prior to the fixed reimbursement fee, Montana Medicaid Home Health reimbursements were made following Medicare policies. The fixed fee is based on the average reimbursement for providers under the cost method previously used to pay providers. The reimbursement fee for a home health service provided on or after July 1, 1997, is $60.43 per visit for nursing or therapy services, $26.99 per visit for home health aide visits, and 90 percent of the amount allowable for specific medical supplies and equipment under Medicare.

In fiscal year 1995-96, the bureau implemented a service limit for home health services as a mechanism to reduce program costs and identify recipients better served by alternative cost-effective programs such as the Home and Community Based Services Program. Skilled nursing visits are limited to 75 visits per recipient per fiscal year. Other home health services are limited to a combined maximum of 100 visits per fiscal year. The bureau prior-authorizes services exceeding the limits when it is medically necessary and another alternative does not exist. All home health aide services must be prior-authorized by the department.

Provider rate increases included in fiscal year 1997-98 appropriations were not paid for a three month period while program personnel confirmed growth in home health services were within the legislatively-mandated rates of 5.25 percent. To track program growth rates, the bureau developed a provider report showing home health service usage. By law, providers have up to one year to submit a Medicaid claim for payment. The new report allows the bureau to determine current fiscal year program usage. After the bureau determined current home health services growth was within mandated rates, provider rate increases were retroactively paid.

In fiscal year 1997-98, bureau staff began reviewing the types of home health services provided to high-cost recipients. They determined some of the recipients could be more effectively served by the Personal Assistance Services and Home and Community Based Services Programs. As a result of this review, staff began the process of moving these recipients into the lower cost programs, further reducing Medicaid home health expenditures.

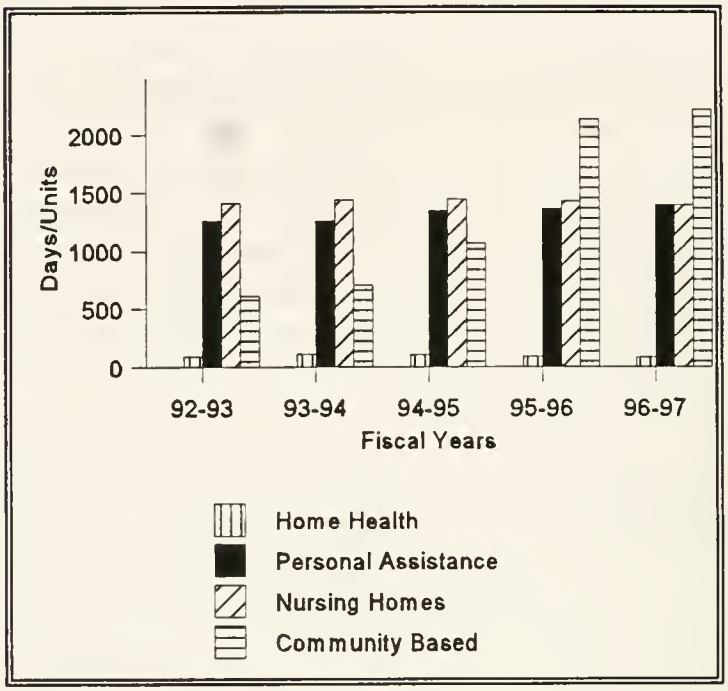
The culmination of the changes resulted in a reduction of $1.4 million in home health expenditures from fiscal 1995-96 to fiscal year 1997-98. The changes also reduced the number of recipients receiving home health services by 447 and reduced the average annual cost of home health services per recipient by $473.

Have Expenditures and Numbers of Medicaid Recipients in Nursing Homes Declined?

One objective of in-home services programs is to reduce nursing home expenditures by serving recipients in their homes. We reviewed nursing home expenditures over the last five years. Our review showed expenditures increased from $76,556,793 in fiscal year 1992-93 to $95,680,205 in fiscal year 1996-97. Division personal attribute this increase to provider rate increases not from increases in usage. Expenditures remained relatively constant from fiscal year 1994-95 to 1996-97. Although expenditures increased, overall, the number of Medicaid recipients in nursing homes declined between fiscal years 1992-93 and 1996-97.

Figure 2 shows days/units comparison between nursing homes and the three in-home Medicaid programs. Days/units refers to the number of nursing home days or units of home health, personal assistance services, or case management services received by Medicaid recipients during the fiscal year. While nursing homes and home health services days/units have declined since fiscal year 1994-95, personal assistance and home and community based services have increased. Both nursing homes and home and community based services are provided to Medicaid recipients requiring nursing home level of care. It appears bureau policy resulted in movement of eligible recipients from high cost services such as nursing homes and home health services into lower cost programs of personal assistance and home and community based services.

Figure 2
Comparison of Number of Days/Units by Program
(Fiscal Years 1992-93 through 1996-97)



Source: Compiled by the LAD from bureau statistics.

Figure 2 shows the intent of the three programs to reduce the number of Medicaid recipients in nursing homes is being met. We reviewed program controls which ensure services provided to recipients are appropriate. We did not determine if the services were needed.

Chapter III - Home Health Program

Introduction

Home health services are defined in the Administrative Rules of Montana (ARMs) as services provided by a licensed home health agency to a recipient considered homebound in the recipient's place of residence for the purposes of postponing or preventing institutionalization. The program also serves recipients who are not homebound but cannot readily obtain needed medical services other than through a home health agency. Home health services include skilled nursing services, home health aide services, physical therapy, occupational therapy, speech therapy, and medical supplies and equipment suitable for use in the home. Services are designed to be delivered on a part time or intermittent basis.

Home health agencies must be licensed by the Department of Public Health and Human Services, be Medicare certified, and enrolled as a provider with the Medicaid program. Home health services must be ordered by the recipient's attending physician. The services needed by the recipient must be documented as part of a written plan of care. The plan of care is to be reviewed and renewed by the recipient's attending physician at least every 60 days.

Why Test Program Controls?

A control structure is a process designed to provide assurance management will achieve their objectives. A control structure provides management better accountability over program operations. The Community Services Bureau is responsible for ensuring the control structure over its programs is functioning in such a way as to ensure providers comply with federal and state requirements. The requirements are developed in part to control Medicaid expenditures. We tested the bureau's control structure over the Home Health Program.

Controls Over Home Health Services Could be Improved

We reviewed 106 Medicaid recipient charts from 23 home health providers to ensure providers follow program requirements for home health services. Program requirements tested included determining:

- Homebound status of recipient was certified on the plan of care.
- Lack of alternative services for medical treatment was clearly documented in the chart if recipient was not homebound.
- The plan of care was prescribed by the attending physician.

- The plan of care was reviewed by a physician every 60 days.
- Treatment goals and progress toward goals were documented.
- Chart documentation matched provider billing claims.

Our review of recipient charts identified high error rates which indicates several program controls could be improved. The control concerns relate to the home health policy and procedure manual, provider compliance reviews, provider education, and policies and procedures for physician's approval of plans of care. The bureau has already taken steps to improve the controls. The following sections discuss our findings.

Policy and Procedure Manual

Policies and procedures help to guide providers in performing their Medicaid program responsibilities in a consistent and accurate manner. A policies and procedures manual helps strengthen program controls over operations and helps assure continuity if staffing changes occur in the Community Services Bureau or in the home health agency.

The Medicaid Home Health Program staff developed a procedures manual outlining program requirements and policies. The Medicaid fiscal intermediary, a private company contracted to process provider Medicaid payments, sends the manuals to home health agencies. We found a number of the home health agency personnel were not aware there was a manual for the Home Health Program. Billing personnel in the home health agencies received the manual since it contained billing information and was sent by the fiscal intermediary. Some home health caregivers did not see the manual, and they stated they were unaware of the specific requirements for the Medicaid Home Health Program. Bureau staff were unaware of the confusion relating to the manual.

One of the requirements outlined in the manual relates to chart documentation. During our testing, we found some home health caregivers did not comply with chart documentation requirements. Due to the lack of chart documentation, we were unable to determine if some Medicaid recipients were eligible for the services they received.

By ensuring home health caregivers obtain the home health policy and procedure manual bureau staff can assist providers in understanding

program requirements specific to Medicaid home health services. Manuals also provide staff with criteria to measure provider compliance with guidelines.

Recommendation #1
We recommend the Community Services Bureau ensure home health caregivers receive the program policies and procedures manual.

Prescribing Physician Required to Sign Written Plans of Care

Under state Medicaid requirements, home health agencies are required to develop a written plan of care outlining the recipient's treatment. The plan is to be prescribed by the recipient's attending physician. The physician's signature on the plan of care is intended to serve as a control over the treatment received by the recipient from the home health agency. If the physician does not review the plan of care prior to the start of treatment, the control does not operate as it is intended. Plans of care are to be renewed (certified) every 60 days.

During our review of recipient charts, we found home health agencies had:

- Physicians sign plans of care after the treatment was administered.
- Plans of care without dated physician signatures.
- Plans of care with dates changed without the physician initialing the changes.
- Plans of care signed by emergency room doctors instead of the attending physician.
- The physician on staff at the home health agency sign plans of care when the attending physician did not return a signed plan of care.
- Verbal orders that were not dated to show when approval of the treatment was obtained from the attending physician.
- Verbal orders which were not initialed by a nurse.

As a result of poor documentation, in many cases we were unable to determine if the physicians had approved treatment prior to the start of the recipient's treatment.

The Montana Medicaid Home Health Program staff have not developed ARMs, policies or procedures defining who is the attending physician, allowing physicians to approve the plan of care verbally prior to the start of treatment, or requiring attending physician signatures on the written plan of care before the start of treatment.

The federal Medicare Program has the same requirements as the Medicaid program for a written plan of care prescribed by the recipient's attending physician. Under Medicare, the home health agency is allowed to obtain a verbal order from the attending physician prior to the start of care. The home health agency is then required to obtain a written signature on the plan of care at a later date.

Bureau staff relied on the providers following Medicare guidelines for prescribing physicians, verbal orders, and attending physician's signatures and dates. The staff had not considered a need to implement policies and procedures for proper documentation techniques. Bureau personnel stated they usually piggyback on Medicare rules for home health when they are applicable and make sense. However, bureau staff have not adopted rules stating the Home Health Program will follow Medicare requirements for physician's signatures, dates and verbal orders.

Recommendation #2

We recommend the bureau develop rules, policies, and procedures outlining written plan of care requirements for:

- **prescribing physicians,**
- **physician's signatures,**
- **dates, and**
- **verbal orders.**

Compliance Reviews and Provider Training Needed

By issuing provider manuals, rules, policies, and procedures to home health caregivers, the bureau will have some assurance providers are aware of Home Health Program requirements. The bureau then must ensure home health providers are complying with the requirements.

There are two control elements bureau staff could utilize to ensure home health providers comply with program requirements: compliance reviews and provider education. Staff have not implemented either method for home health providers for this program. Compliance reviews and provider training would help ensure situations such as those described below would not occur.

Absence of Alternative Services Not Documented

The Medicaid Home Health Program serves recipients who are homebound and require either skilled nursing care or therapies. The program also serves recipients who are not homebound but cannot readily obtain needed medical services other than through a home health agency. The procedure manual states absence of alternative services must be documented in the recipient's chart.

In January 1997, bureau staff sent a memorandum to the Montana Association of Home Health Agencies (MAHHA) clarifying the providers' responsibility to document lack of alternative services. The correspondence states:

> "according to the rules, a person who is not homebound can only receive home health services when "the recipient cannot reasonably obtain needed medical services other than through a home health agency." By providing services to a non-homebound individual an agency is assuring that there is no other means to obtain services or there is no other reasonable alternative. Technically this is required in order to obtain Medicaid reimbursement for the services. In order to provide services to those individuals who are not truly homebound, we must work toward better documentation of why such services must be delivered by a home health agency."

We found numerous claims submitted in November and December of 1997 which did not document the lack of alternative resources, ten months after the bureau issued the written statement to MAHHA.

Of the 23 home health agencies visited, 15 did not document the lack of alternative services in the recipient's chart. Fifty-six of 106 recipients in our sample were not homebound. Fifty-three of the 56 charts did not have the lack of alternative services documented. In other words, of the clients which required documentation of lack of alternative services, 95 percent were not documented. Without documentation of lack of alternative services, we were unable to determine if the recipients were appropriately receiving home health services. For our sample, we found home health providers were paid $15,581 in January 1998 for services we were unable to determine were in compliance with program requirements.

Service Delivery Settings Were Inappropriate

During our review of recipient charts, we found six recipients who received services delivered in places other than their place of residence. Four recipients were children who received services while in school, one received services in a day care setting, and the sixth received services while on a trip to eat at a restaurant. This represents 5.7 percent of all recipients tested and 10.7 percent of recipients who were not homebound.

State and federal regulations require home health services be delivered in the recipient's home. The provider manual states Place of Residence includes a recipient's own home, a personal care facility, a foster home, a group home, a rooming house, or a retirement home. Place of Residence does not include schools, Adult Day Treatment Centers, or Developmentally Disabled Day Treatment Programs.

We found services provided in settings other than the home were provided by either physical or speech therapists, most of whom were on contract with the home health agency. The therapists were providing services at the convenience of the recipient, not because of the absence of alternative services, and as a result provided the services outside of program requirements. The services provided appeared to be necessary treatment for the recipients, however, billing the services as home health services was not appropriate under federal and state program guidelines. Home health providers were paid $1,873 in January 1998 for services provided to the six recipients and delivered in settings other than the home.

Billing Errors

During our testing, we compared chart documentation of services provided to billing documentation. We found some home health agencies billed for services which the recipient did not receive. For example, one agency incorrectly billed home health services when the billing personnel transposed the recipient's identification number on the claim submitted for payment. The transposed number was the identification number of another Medicaid recipient receiving services in another city. The claim was paid under the transposed number, thereby recording the payment and services as provided to a recipient the home health agency had never seen. Rather than correct the billing error, the home health agency applied the payment to the account of the recipient they had seen.

In addition, we found seven home health agencies submitted claims listing ten services which had not been provided to recipients. The fiscal intermediary denied payment for two of the claims submitted by one agency. The remaining agencies received payments for the services. In one case, we were unable to determine if the provider overbilled the Medicaid or Medicare program for the home health services.

The home health agencies accepted $1,389 in Medicaid home health payments for services they did not provide to recipients in our sample. All of the providers stated the over billings were the result of billing errors.

Proper Charting

Section 53-6-160, MCA, states a provider has a duty to exercise reasonable care to ensure the truthfulness, completeness and accuracy of all documents for purposes related to the Medicaid program. To ensure recipient charts are complete, they should show a record of all treatment received by the recipients.

We found, during our review of recipient charts, several instances where providers had changed information in the recipients' charts or failed to correctly document observation and assessment of a recipient's condition during the home health visit. One nurse copied a charting note which listed a number of observations and assessments. She used copies of that chart note to record her patient visits from June 17, 1997, until our audit found the problem on March 17, 1998. The recipient's

plan of care required the nurse to observe and assess the recipient's cardiopulmonary, neurological, gastrointestinal, and genitourinary functions as well as ensure the skin integrity of the client had not broken down. Since these assessments were not documented during the period we reviewed, we could not determine if the recipient's condition relating to any of these functions and conditions changed during this period of time.

In addition, we found:

- Plans of care where the frequency of the nurses services were increased over the original authorized amount. We were unable to determine if the attending physician approved the increase as the changes did not have initials to show who had made the changes. The changes were also not dated to show they were completed prior to the physician approving the plan of care.

- Certification periods altered in records. The changes were not initialed or dated.

- Chart notes with numerous visits combined into a single note, so we were unable to determine when the provider gave the treatment to the recipient and what the treatment consisted of.

- Physician and nurse signatures on plans of care without dates to show when the plans were reviewed and approved.

Due to providers' failure to follow proper charting principals, we were unable to determine if services billed for the recipients discussed above were delivered in accordance with program requirements for home health services. As a result, we question $2,395 in Medicaid home health expenditures tested in our sample. In addition, we question $7,837 in Medicaid home health expenditures relating to the nursing services which had copied nurse notes as we were unable to determine from the records if the observation and assessment of the client was provided as required in the written plan of care.

The medical records maintained by providers are the legal documentation of services provided to Medicaid recipients and a basic component in determining the adequacy of treatment and charges. The bureau relied on the providers to properly document information in the

home health recipients' charts. Based on the results of our audit, the bureau cannot expect that all providers will meet documentation requirements. To ensure providers maintain proper charting records the bureau should periodically review provider charts. A review process could heighten providers' awareness of program requirements and encourage them to sign plans of care before treatment begins, date physician signatures, and initial and date changes to plans of care.

Compliance Reviews and Education Needed

Section 53-6-160 (2b), MCA, states a provider has a duty to exercise reasonable care to ensure that a claim submitted to the department for payment under the Medicaid program is one for which the provider is entitled to receive payment and that the service is provided and billed according to all applicable Medicaid requirements. Our home health services testing showed providers do not understand and follow program requirements. A compliance review process over Medicaid home health would help ensure providers comply with program requirements. A compliance review could include provider recipient chart reviews to ensure providers complied with specific federal and state requirements over home health services. Determining medical necessity of the treatment could also be included. The compliance review process could heighten provider awareness of Medicaid program requirements, thus reducing errors and overpayments to providers.

If the errors were in fact billing errors based upon misunderstandings, then provider education would help ensure all providers and their employees are aware of requirements specific to the Medicaid Home Health Program and when home health services are appropriate.

Recommendation #3

We recommend the bureau:

A. Implement a compliance review process for home health providers.

B. Develop a provider education program for home health providers.

Chapter III - Home Health Program

Control Structure Over Home Health Payments are Not Adequate

The control structure over home health payments is not functioning in such a way as to ensure providers comply with federal and state requirements. We found 66 recipient charts, or 62 percent of our sample, did not comply with program requirements. We determined of $38,845 tested, $18,942 should not have been paid because providers failed to comply with program requirements. This represents an error rate of 48.76 percent. Based on the error rate of 48.76 percent found in our statistical sample, we project $31,569 in questioned costs out of $64,744 of home health expenditures in January 1998. Based on our testing, we conclude controls over Medicaid home health payments were not adequate.

As noted in Chapter II, the bureau implemented several methods to ensure home health program growth was appropriately reduced over the last three years. Bureau personnel indicated they had concentrated on developing compliance reviews and provider education for personal assistance services and home and community based services as expenditures for these two programs are in excess of $25 million a year. Bureau personnel also stated they had relied on provider assurances they were following program requirements. Now that the bureau has implemented provider compliance reviews and education for their larger programs they can concentrate on implementing effective controls over Medicaid home health services.

Bureau Concurs With Recommendations

The bureau agrees with our recommendations for improving controls over home health expenditures. They completed reviewing providers not selected for review in the audit. Bureau staff negotiated a contract with a private company to conduct a yearly review of home health providers which will include determining if the services provided were medically necessary. Bureau staff are developing provider education programs and staff are in the process of developing a policy manual which should be completed and released December 1998. The staff appointed a provider work group to review the rules.

Cost Efficiency Measures Which can Reduce Medicaid Costs

Federal Medicaid requirements include providing Medicaid services in the most efficient and cost-effective manner possible. During our review of home health provider payments, we identified cost-effectiveness measures related to basing home health fees on units of service, medication management, and developmentally disabled services. The following sections discuss these issues.

Home Health Reimbursements Based on Length of Time Provider Spends in the Home

In fiscal year 1996-97, the bureau implemented fixed service fees for home health. In fiscal year 1997-98, the fee was $60.43 per visit. The length of the visit is not a factor in payment.

Both the Personal Assistance Services Program and Home Health Program provide services to Medicaid recipients in their homes. The two programs use plans of care to determine the type and frequency of services to be provided to recipients. The Personal Assistance Services Program pays providers $10.72 per hour for services; however, providers are required to submit claims and are reimbursed based on units of service. A unit of service is a 15-minute period. Home Health providers are reimbursed based on a recipient visit. Alternative methods for determining home health provider reimbursements exist. One method to provide consistency between personal assistance services and home health services reimbursements is to base home health reimbursements on the length of time the provider is in the home working with the client.

Recipients Sent a Questionnaire

We sent a questionnaire to the 106 Medicaid recipients selected for chart review. As part of the questionnaire, recipients were asked how long the home health nurse was in the home. Sixty-one recipients returned questionnaires with information on the length of the home health visit by nurses.

Savings of Home Health Reimbursements Based on Units of Service

Using the information provided by the recipients, we determined the cost savings of home health services if reimbursements are based on the length of the visit. We used the bureau's home health reimbursement of $60.43 a visit to determine this payment amount. A reimbursement based on the length of the home health visit would have to recognize both the provider's fixed administrative costs and a prorated cost for the caregiver based on the length of time the caregiver is in the home. For

example, to determine cost savings for recipients sampled, we first calculated an administrative portion of the current home health fee. Twenty percent of $60.43 or $12.09 was used for the administrative portion. (This amount is used only for illustration purposes. An actual amount of administrative costs would need to be determined prior to implementing this methodology.) We then calculated a prorated cost for the caregiver by dividing the remaining $48.34 ($60.43 - $12.09) by 4 to get an amount for each 15 minutes of services ($12.09). The administrative portion and the prorated costs were added to determine the prorated cost for home health visits based on 15-minute increments. The savings amount was determined using a prorated amount based on the length of the home health visit. Based on the length of service information provided in the questionnaire, if each recipient sampled received a single home health service from providers, payments would have been $3,685. Using the methodology described above, the providers in our recipient survey would have been paid $2,731 for the same number of services, a savings of $954. Results are shown in Table 1.

Table 1
Savings Based on Length of Time Provider is in the Home

Recipients	Length of Home Health Visit	Provider Payment	Payment Based on Length of Visit	Savings/ Additional Costs
13	15 minutes	$ 785	$ 314	$ 471
21	30 minutes	$ 1,269	$ 761	$ 508
8	45 minutes	$ 483	$ 387	$ 96
17	60 minutes	$ 1,027	$ 1,027	$ 0
2	120 minutes	$ 121	$ 242	$ (121)
Total		$ 3,685	$ 2,731	$ 954

Source: Compiled by the LAD from recipient surveys.

When we suggested basing home health payments based on the length of time, bureau personnel stated they determined Medicaid program

requirements would allow them to pay providers based on the units of service provided rather than a per visit amount.

Recommendation #4
We recommend the bureau consider a cost per unit of service reimbursement for home health payments.

Medication Management

As part of the home health chart review, we determined the type of services provided to Medicaid recipients by home health providers. We found 38 of 106 clients, or 36 percent of the recipients, primarily received medication management for prescription drugs. Under the State Nurse Practice Act, only a registered nurse can administer prescription drugs.

Medication management consists of a nurse coming into the recipient's home to fill a medication box. The boxes are divided into compartments corresponding with times of the day and days of the week. The recipient takes the medication from the box at the time and day corresponding with the compartments of the box. This service was provided to 15 of the recipients receiving medication management services. The other recipients were diabetics requiring insulin syringes prefilled by the nurse. We found the cost of providing medication management services for recipients in our sample was $9,043. Of this amount, providers were paid $6,026 for prefilling medication boxes and $3,017 for prefilling insulin syringes.

Currently, the Community Services Bureau has no other mechanism for providing medication management services to Medicaid recipients qualifying for home health services. Prior to our audit, the bureau identified medication management as a service which could be provided in a more cost-effective manner. The bureau has been working with the Medicaid Pharmacy Program, administered by Health and Policy Services Division, to develop a more cost-effective delivery system.

The bureau began the process of testing a system which consists of the pharmacist filling the box with the delivery performed by a personal

assistant instead of a nurse. The Personal Assistance Services Program currently provides prescription medication delivery services. The cost of delivery is $10.72 per hour plus the cost of transportation. The cost of medication management services provided by home health providers is $60.43 per visit regardless of how long it takes to fill the medication boxes. Under the system being tested, the Medicaid program would pay for the acquisition of the delivery system under Medicaid's durable medical benefit and the cost of the drugs and dispensing fee under Medicaid's pharmacy benefit.

Based on the test results, the bureau will determine the feasibility of implementing the new system statewide. The new system could be used for clients receiving medication management services for prefilling medication boxes. Diabetic clients would still require medication management services for prefilling syringes. Bureau staff have not explored alternative methods for prefilling syringes.

The bureau agrees with our recommendation. Staff will try and determine a more cost-effective medication delivery method for home health recipients by February 1, 1999.

Recommendation #5

We recommend the Medicaid program implement alternative methods for delivering medications, including insulin, in a more cost-effective manner.

Services for Developmentally Disabled Recipients

We reviewed the primary diagnosis of the 106 recipients selected for chart review. Eighteen, or 17 percent of the recipients, were developmentally disabled. At a cost of $60.43 per visit for services, the Medicaid Home Health Program paid $5,616 to providers for services to developmentally disabled clients selected for review in our sample. Services included medication management, wound care, and speech therapy.

The Montana Medicaid Program has a separate waiver program for developmentally disabled recipients. The federal waiver and state

statute give the department the authority to develop a comprehensive program for treatment of developmentally disabled clients. For example, the Developmental Disabilities (DD) Program has authority to develop cost-effective alternatives for their clients which could include services for administration of medications, wound care, or other services currently covered by home health. This authority includes providing private duty nursing services to recipients at a cost of $20 per hour.

All services considered to be entitlements under the Medicaid program must be provided to eligible recipients who qualify for them. The state plan for Medicaid, the agreement between HCFA and Montana, outlines the services which must be provided. Bureau personnel indicated the DD Program has a policy of using as many of the required services as possible. By using other Medicaid programs to pay for medical services for their population, the DD Program can use their budget authority for other services. The required medical services can be provided under the DD Program more cost-effectively but would require the DD Program to use their appropriation authority for the medical services.

Prior to beginning our audit, the bureau began researching a plan to transfer a portion of home health's budget authority to the DD Program to provide home health services to developmentally disabled clients. This would allow the DD Program to develop a more cost-effective method for delivering home health services to their recipients. An example would be the use of private duty nurses at a cost of $20 an hour rather than $60.43 a visit for home health nurses.

The bureau and the DD Program agree with our recommendation to develop a more cost-effective method of delivering services to developmentally disabled recipients. The bureau plans to transfer a portion of the appropriation authority for home health services for people with developmental disabilities to the DD Program by July 1, 1999.

Recommendation #6

We recommend the bureau and the Developmentally Disabled Program develop the most cost-effective method of delivering home health services to developmentally disabled recipients.

Chapter IV - Personal Assistance Services Program

Introduction

Personal assistance services are medically necessary in-home services provided to Medicaid recipients whose health condition causes them to be functionally limited in performing daily living activities such as dressing, grooming, meal preparation, and bathing. Personal assistance services are intended to prevent or delay institutionalization into hospitals or nursing homes by providing medically necessary, long-term maintenance or supportive care in the home. Personal assistance includes help with activities of daily living, household tasks, and escort services.

To qualify for personal assistance, a person must be Medicaid eligible and demonstrate a medical need for personal care. Personal assistance services must be prescribed by a physician, supervised by a licensed nurse, and provided in a home setting. Personal attendants provide the assistance services in the recipient's home. A nurse must supervise the attendant and make scheduled home visits to review the written plan of care, assess the quality of services provided, and provide training to the attendant. The personal assistance attendant may be paid only for the hours and tasks authorized by the supervising nurse in the written plan of care. Personal assistance services provided in licensed foster or group homes must be prior-authorized by the department. Personal assistance services may be authorized when the person's medical needs are beyond the scope of services normally provided by programs funding services in foster or group home settings.

As part of implementing a multiple personal assistance provider system from a single provider system, the bureau changed to a fee for service payment method in fiscal year 1995-96. This reduced the rate from $11.03 to $10.56 an hour. The reimbursement fee for personal assistance services provided in fiscal year 1997-98 was $10.72 per hour.

The bureau separated the state into eight regions. Department program officers in each region conduct yearly compliance reviews on personal assistance providers in their area. Officers also act as resources for providers who have questions regarding the program.

Licensing of Attendants Studied

Attendants provide assistance services such as personal care, household tasks, meal preparation, and shopping. While attendants provide services under the Personal Assistance Services Program, there are no licensing or registration requirements for the attendants. Senate Joint Resolution 16, 1997 Legislature, required the bureau to study the feasibility of and examine issues related to developing a voluntary registry of home attendants. The bureau completed a report and recommendations to the 1999 Legislature on this issue. The recommendations include reviewing current registries to determine what information can be linked together and made available to the public, and developing a public education campaign regarding the hiring of home attendants.

Recipients can Participate in the Self-Directed Program

Recipients of personal assistance services can participate in the Self-Directed Assistance Services Program. This program allows recipients to act as an employer of their personal attendants. One condition of participation is the recipient's ability to direct his/her employee. The recipient hires, directs, and fires the employee. Self-directed program providers are responsible for paying the personal attendant based on time sheets signed by the recipient.

Included in the program is the option of having the personal attendant provide health maintenance activities such as wound care, medication management, and bowel and bladder programs. This option reduces the cost of home health services for health maintenance activities. The efficiencies result because personal assistance services are provided for $10.72 an hour while home health services are provided at $60.43 a visit.

Controls Over Personal Assistance Services Could be Improved

Thirty-nine of the 106 Medicaid recipients selected in our home health sample received personal assistance services during November or December 1997. We reviewed billing information listed on the recipient profiles to ensure providers followed program requirements for billing personal assistance services. Billing requirements included:

- Recipients did not receive more than 40 hours of personal assistance services in a week.

- Services provided in excess of 40 hours a week received prior-authorization from the bureau.

- Self-directed recipients did not receive home health services for health maintenance activities if they had elected to have their self-directed attendant perform these activities.

We identified several issues pertaining to controls over personal assistance services which could be improved. These issues relate to personal assistance service weekly limits, self-directed health maintenance elections, and provider compliance reviews.

Personal Assistance Services Weekly Limits

The personal assistance program allows a recipient to receive up to 40 hours of personal assistance services a week. Personal assistance hours can be provided in excess of this amount with written department authorization. We found 7 of the 39 recipients received services in excess of the weekly personal assistance program limit without prior-authorization from the bureau. We determined providers in our sample were paid $1,066 for services in excess of weekly limits without prior-authorization from the bureau.

We determined one provider overbilled all personal assistance services for recipients reviewed in the sample. We further reviewed personal assistance service payments made to this provider in September, October, and November 1997. We found the provider overbilled personal assistance services for 24 of 31 recipients without prior-authorization from the department. We determined this provider was paid $1,391 for unauthorized services.

The bureau does not currently have a mechanism allowing them to review personal assistance services in excess of the weekly limits. Providers can submit bills for a day, a week, two weeks, a month or any other period they desire. As a result, it is not possible to generate a report listing providers who submitted claims with amounts in excess of the weekly limits. If providers were required to submit personal assistance claims on a weekly basis, the bureau could generate a report to determine which agencies are billing in excess of the weekly limits.

The Medicaid Management Information System (MMIS) is used by the fiscal intermediary to process personal assistance claims. As currently programmed, the system uses a "rolling" weekly span for Medicaid claims. As a result of the "rolling" span, a provider can submit for a week of services beginning January 1 and submit for a week of services beginning January 4, and be paid for both. The system does not have a control to flag claims which are submitted for overlapping weeks. A random review of provider claims by bureau staff could be used to identify these types of claims. The bureau already reviews provider charts and billing information when conducting compliance reviews. Ensuring providers do not bill for overlapping weeks could be included in the review once providers are required to bill on a weekly span.

Recommendation #7

We recommend the bureau:

A. Require providers to submit claims for personal assistance services covering a week time period.

B. Establish a limit parameter on the MMIS which would identify billings submitted in excess of the weekly limits for personal assistance services.

C. Include a review of personal assistance claims to ensure providers do not bill for overlapping weeks during provider compliance reviews.

Self-Directed Health Maintenance Elections

In our sample, three recipients elected to have their self-directed personal attendant perform one or more health maintenance tasks. After this election was made, the recipients' conditions changed and they needed a home health agency to perform the health maintenance tasks. The recipients did not change their plan of care to reflect the change in their conditions, nor did they change their election to have health maintenance activities performed by their self-directed attendant. The written plans of care for these recipients included the time spent performing health maintenance activities under both the Self-Directed Assistance Services Program and the Home Health Program. This resulted in the Medicaid program paying for the recipients' health

maintenance activities twice, once through the Self-Directed Assistance Program and once through the Home Health Program. We question $1,511 in Medicaid Home Health Program costs for these recipients in January 1998.

It appears recipients are not aware of the need for an amendment to the self-directed plan of care if their condition changes after they complete their election for health maintenance activities. Department policy requires the recipient to update his/her plan of care every six months. Bureau personnel stated additional clarification needs to be completed regarding the amendment process for health maintenance activities. They also stated additional recipient education should occur to make recipients aware of their responsibilities relating to changes of condition and use of home health services.

In addition, the compliance review process currently used by the bureau does not include reviewing both home health services and self-directed assistance services to ensure double billing has not occurred between the two programs. If both were reviewed, the bureau could determine if recipients electing to have health maintenance activities performed by their self-directed attendant were also using home health providers to perform these functions.

Recommendation #8

We recommend the bureau:

A. **Provide Medicaid self-directed personal assistance service recipients clarification and education relating to amendments to plans of care if their condition changes.**

B. **Review both self-directed assistance services and home health services provided to recipients during compliance reviews.**

Compliance Reviews not Consistent

Regional program officers perform annual compliance reviews of all personal assistance providers. The officers review a sample of recipient charts to determine if providers are in compliance with program requirements. Compliance is determined based on providers meeting standards outlined for the program. The officer determines if the provider meets the standard, meets the standard with comments from the bureau, or does not meet the standard. In addition to chart reviews, regional program officers conduct home visits on a sample of personal assistance services recipients. During a home visit the officer interviews the recipient to determine if the recipient is receiving services, if there is any problem with the services, and if the officer can assist the recipient in anyway. The officer then summarizes the findings in a compliance review report.

We examined compliance reviews completed in fiscal years 1996-97 and 1997-98 to determine if officers were consistent in applying program criteria to providers they reviewed. The following sections discuss our findings.

Provider Final Determinations not Based on Review Results

During testing of compliance reviews, we found the final determination of whether the standard was met, met with comments, or not met did not always agree with the information gathered from the chart reviews. For example, in one case none of the individual charts reviewed met the standard. The determination on the final report indicated the provider met the standard with comments from the bureau.

Section 46.12.558 (8), ARM, states the provider must meet all standards in 90 percent of the cases to be considered in compliance. If 90 percent compliance is not met, the provider will be given the results of the review and a second compliance review will be scheduled. Program officers do not always tabulate the results of the individual chart reviews before the final report is completed to determine what percentage of the charts are in compliance. Without tabulating the results of the individual chart reviews, a regional program officer's determination of whether the provider met the standard is based on how the officer thinks the provider did, not on the actual results of the review.

Recommendation #9
We recommend the bureau establish procedures to ensure the determination of whether a personal assistance provider met standards is based on the results of the charts reviewed.

Home Visit Information not Consistent

We determined regional program officers did not consistently gather the same type of information from recipients during home visits. For example, the bureau developed a reporting form for home visits listing information to be asked of the recipient about the services they received. Some officers used the form to conduct the reviews, others did not use the form and asked the recipient a few questions, and others used the form and asked additional questions. The home visits are used as part of the compliance review process to help determine the adequacy of provider services. Without consistent information gathered by officers, the bureau cannot ensure all providers provide adequate services to recipients.

We also determined regional program officers do not always retain the records of the home visits after they complete the provider's final compliance review report. MOM 1-0830.21 states that among records having legal value are those showing the basis for action. The MOM essentially requires the bureau to maintain supporting documentation.

Bureau staff do not review the worksheets used to gather information from Medicaid recipients during home visits. As a result, they were unaware of the differences in the review process followed by the officers.

Recommendation #10

We recommend the bureau:

A. Implement a home visit process which ensures regional program officers obtain the same information when conducting the reviews.

B. Ensure regional program officers retain records of home visits.

C. Periodically, review worksheets used in provider compliance reviews to determine if officers have followed bureau procedures relating to home visits.

Bureau Concurs With Recommendations

The Community Services Bureau concurs with our recommendations for improvements of controls over the Personal Assistance Services Program. Bureau staff are testing an edit on the MMIS which will flag claims submitted in excess of the established parameter. They are developing a clarification of the self-directed health maintenance election policy for the provider manual and are developing a consumer education process for recipients. Staff have also tested an improved compliance review process designed to ensure consistent measurement of compliance with standards and documentation of home visits.

Chapter V - Medicaid Home and Community Based Services Program

Introduction

The Medicaid program was granted a waiver by the Health Care Financing Administration (HCFA) for the Home and Community Based Program. The waiver allows Medicaid recipients to receive individually prescribed and arranged services according to their needs. This program provides home and community based (waiver) services to elderly or physically disabled Medicaid recipients who require nursing home or hospital level of care but prefer to receive services in their homes or in community settings.

Waiver services include case management, homemaking, personal assistance, adult day care, respite, habilitation, medical alert monitors, meals, transportation, environmental modifications, respiratory therapy, nursing services, adult residential care provided in either a personal care facility, assisted living facility or adult foster home, service dogs, and specialized services for recipients with a traumatic brain injury. Section 53-6-501, MCA, defines traumatic brain injury as an injury to the brain caused by an external force or brain damage caused by an internal occurrence such as a stroke. The term does not include degenerative or congenital conditions.

In order to be considered for traumatic brain injury (TBI) services, recipients must be assured of placement into appropriate living arrangements after they complete the program. Until the TBI programs find placements for recipients, they remain untreated and in their current living situations: nursing homes, hospitals, or at home with care provided by Medicaid. Five recipients identified as needing TBI services currently reside in nursing homes. Until funding becomes available for placements following TBI treatment, they will not receive specialized treatment for their injuries. Some TBI recipients require supported living placements. The bureau included appropriation authority for additional supported living placements in their budget request to the 1999 Legislature.

Bureau Contracts With Agencies for Case Management Services

The bureau contracts with agencies such as hospitals, home health providers, and city-county health departments to provide case management services to all waiver recipients. Case management teams are headquartered in Missoula, Billings, Helena, Great Falls, Bozeman, Sidney, Miles City, Kalispell, Butte, Lewistown, Havre, Polson, and Roundup. Case management services include development of cost-effective, recipient specific, plans of care. The plan of care is developed by the case management team in conjunction with the recipient and the attending physician. The cost of the plan of care must be less than the cost of institutionalization. The plan of care is reviewed by the team at least every six months and revised if the recipient's condition changes.

Teams contract with Medicaid providers for recipient services. Regional program officers conduct compliance reviews on case management teams to determine if the teams comply with program requirements. Officers also act as resources for waiver providers who have questions regarding the program.

Number of Recipients Served Contingent on Funding

This service area is not an entitlement and the number of persons served is constrained by the funds appropriated by the Montana legislature. When all funds are committed, eligible individuals are placed on a waiting list until resources become available. Recipients on the waiting list may still obtain services through the Home Health Program or the Personal Assistance Services Program if they are Medicaid eligible and meet program criteria. Some recipients on the waiting list reside in nursing homes while waiting for services under the waiver program.

The bureau has implemented a "slot" system to ensure expenditures stay within appropriation amounts. Recipients are served based on their needs. Needs are categorized under the waiver program by slots: elderly, physically disabled, supported living, adult residential, and post-acute residential traumatic brain injury services. Each case management team is assigned a certain number of slots based on budgetary restrictions. This system allows the bureau to ensure case management teams stay within program budget restrictions.

Controls Over Home and Community Based Services Could be Improved

Twenty-four of the 106 Medicaid recipients selected in the home health sample received case management services and other waiver services during November or December 1997. We reviewed billing information listed on the recipient profiles to ensure providers followed program requirements for billing home and community based services.

During our review of the home and community based services, we identified several issues pertaining to controls over waiver services which could be improved. These issues relate to the home and community based services waiting list and rules for TBI services.

Home and Community Based Services Waiting List

We reviewed the waiting list for waiver services. The list included types of services required and current residence of recipients. As of June 30, 1998, case management teams identified 281 individuals eligible to receive waiver services. Recipients on the waiting list require varying types of services. Table 2 presents the types of services and number of individuals needing services.

Table 2
Home and Community Based Services Waiting List
(As of June 30, 1998)

Type of Service Needed	# Waiting for Services
Physically Disabled Adult	111
Adult Residential	72
Elderly	69
Supported Living	16
TBI Services	13

Source: Compiled by the LAD from bureau waiting list statistics.

As shown in Table 2, 72 recipients require adult residential services. We determined 21 of the 72 recipients reside in nursing homes. The other 51 recipients reside in less expensive residential settings such as personal care homes. However, these residential settings are no longer considered appropriate based on changes in their medical condition. If the bureau cannot place these 51 recipients into adult residential services they will be placed into nursing home facilities.

All services considered to be entitlements under the Medicaid program must be provided to eligible recipients who qualify for them. Nursing home services are considered entitlements, thus if funding for waiver services for the 51 recipients is not available the state is required to pay for nursing home services.

House Bill 2 of the 1993 Montana Legislature states: "The Department of Social and Rehabilitation Services is authorized to transfer funds among appropriations for Medicaid primary care, Medicaid nursing care, Medicaid buy-in, state medical, and the Home and Community Based Waiver Program." This statement specifically authorized the department to transfer appropriation authority between Medicaid programs. This language was not included in later sessions. The department is reluctant to transfer appropriation authority between programs without the specific language, even though the department has the authority to transfer appropriation authority from one Medicaid program to another. These types of transfers are known as house adjustments. To clarify the funding we believe the legislature should include the appropriation transfer language in subsequent appropriation bills. With this legislative approval, the department will be less reluctant to transfer Medicaid funds into the waiver program to provide funding for eligible recipients needing adult residential services.

The average daily rate for nursing homes in fiscal year 1997-98 was $69.78. We calculated the cost of providing nursing home care for the 21 recipients in nursing homes is $534,864 per year. The maximum amount the program pays providers for adult residential services is $60 a day. Bureau staff determined the average cost of adult residential care in fiscal year 1997-98 was $44.11 a day. Using fiscal year 1997-98 averages, we calculate the Medicaid program could save between

averages, we calculate the Medicaid program could save between $74,964 and $196,761 by providing adult residential services under the waiver program for the 21 eligible recipients residing in nursing homes. The Medicaid program could save additional funds by appropriately placing the other 51 recipients needing adult residential services prior to their entering a nursing home.

Recommendation #11

We recommend:

A. The legislature include language to allow the department to transfer appropriation authority between Medicaid programs.

B. The department appropriately transfer Medicaid funds into the waiver program to reduce nursing home expenditures.

Home Visits Made by Case Management Teams

The bureau issues case management teams policy and procedure manuals. The waiver services policy and procedure manual contains waiting list criteria. The criteria require the case management team to evaluate medical stability, mobility, independence, judgement or cognitive impairment, and adequacy of current placement. Bureau program personnel indicated case management teams are to visit the recipient in their home to make these assessments. The information gathered is used to prioritize the recipient's need for services and determine the next recipient to receive services when funding becomes available.

We interviewed 7 of the 17 case management teams under contract with the bureau. We determined some teams were not making home visits to all recipients on the waiting list to assess the recipients' conditions and to prioritize their need for services. When questioned, some teams stated because of their workloads they did not make home visits a priority. Others were reluctant to make visits if recipients would not receive services soon. Without completing a home visit to the recipient, the case management team cannot ensure the recipient's evaluation and priority status is correct.

Bureau staff had not considered including the home visit documentation in their compliance review of contracted case management teams. Because they did not review the case management team procedures related to home visits, they were unaware some of the case management teams were not completing the required visits.

Recommendation #12

We recommend the bureau include home visit documentation in the compliance review process of home and community based waiver providers.

Rules for Traumatic Brain Injured Recipients

The bureau does not have rules relating to TBI services provided under the waiver program. Rules would direct providers and help ensure program requirements are followed. Section 2-4-201, MCA, of the Montana Administrative Procedure Act requires all state agencies adopt rules setting forth the nature and requirements of all formal and informal procedures.

Currently, two facilities in Montana provide TBI services to eligible Medicaid recipients. Both programs are nationally accredited rehabilitation programs. The accreditation ensures the facilities provide appropriate treatment for TBI patients. The bureau has received inquiries from other facilities interested in providing TBI services to Medicaid eligible recipients. These facilities are not currently accredited rehabilitation programs and may not provide appropriate treatment for TBI injuries. Rules would establish requirements for appropriate treatment services to Medicaid eligible TBI recipients.

Bureau staff wished to operate the program for a few years before they developed rules for the program. They believed this would allow them to provide better and necessary direction to providers when they developed the rules for the program. The program has been in existence since March 1995.

Recommendation #13
We recommend the bureau implement rules for traumatic brain injury services provided under the Home and Community Based Services Program.

Bureau Concurs With Recommendations

Bureau staff concur with our recommendations for improvements in controls over the Home and Community Based Services Program. Staff included funding for recipients on the waiting list requiring adult residential services in their budget proposal to the 1999 Legislature. They developed an improved compliance review process for the program which includes review of documentation of home visits to recipients on the waiting list. Staff are in the process of updating waiver services rules to include traumatic brain injury services.

Summary

We found bureau staff provide effective administration of the Personal Assistance Services Program and the Home and Community Based Services Program by outlining program goals and objectives. Policy and procedure manuals, provider compliance reviews, and education programs provide needed direction and criteria for measuring provider performance under the programs.

We also found program managers developed and utilize management information systems to allow monitoring of Personal Assistance Services Program and Home and Community Based Services Program activities. The management information allows the bureau to determine if the programs and related controls are functioning as intended and allows for changes when necessary based on information gathered. We found regional program officers and case management teams understand program requirements and are available as resources for recipients and providers of these two programs. Bureau personnel communicate changes in program requirements regularly using policy and procedure manual updates, officer and case management team education, regular staff and provider meetings, and office zipmail. Based on our review, program controls are adequate to ensure provider compliance with program requirements of the Personal Assistance Services Program and

the Home and Community Based Services Program. Our recommendations address improvements for these processes.

Chapter VI - Other Administrative Issues

Introduction

During testing of the Home Heath Program and review of recipient charts, we identified several areas of noncompliance related to Department of Public Health and Human Services' administration of the Medicaid program. As required by auditing standards, these issues are discussed in the following sections.

Sampling Using Statistical Tools and Extrapolation

In fiscal year 1996-97, the Montana Medicaid Personal Assistance Services Program paid providers $15,745,831. The Community Services Bureau administers the Medicaid funds paid to personal assistance providers. The bureau uses a compliance review process as a control to ensure providers comply with program requirements. This control is a component of the department's overall control structure over Medicaid funds.

As part of our in-home services audit, we examined the adequacy of the compliance review process over personal assistance service providers. The review ensures providers appropriately provided services to recipients in compliance with program requirements. Personal assistance providers are reviewed annually by the bureau's regional program officers. The officers determine if providers are in compliance by reviewing a two-week billing span rather than a statistical sample of services provided during the entire year. The officers determine overpayment recoveries for problems found in the two-week period reviewed.

Section 53-6-111, MCA, states the department is entitled to collect from a provider, and the provider is liable to the department for the amount of a payment to which the provider was not entitled, regardless of whether the incorrect payment was the result of department or provider error. Section 46.12.310, ARM, gives the department the authority to assess overpayments based on statistical samples and extrapolation.

As discussed in Chapter III of this report, while reviewing home health service payments made to providers in January 1998, we determined 62 percent of recipient charts did not comply with program requirements. As a result, we project $31,569 in potential overpayments were made to home health providers in January 1998.

By randomly selecting a statistical sample, errors in the total population can be projected without conducting a review of every provider claim and corresponding chart, and thus reducing the time needed to complete the review. The bureau can use this approach to determine a total overpayment amount for individual providers. By expanding the compliance review process of each provider to include the use of statistical samples of all expenditures made to that provider in a fiscal year, the bureau ensures providers comply with program requirements for the entire year and not just for a two-week period. It also requires providers repay all funds to which they are not entitled.

Providers choose to participate in the Medicaid program. As part of their participation, they agree to follow program requirements. Requiring a provider to return overpayments for a particular service based on a statistical sample representative of total annual Medicaid payments made to that provider could provide the needed incentive to ensure providers comply with program requirements. This would strengthen the bureau's control structure over Medicaid funds and ensure providers repay total overpayments for the year rather than a two-week period of time.

Recommendation #14

We recommend the bureau develop a statistical sampling approach to identify in-home service providers' overpayments for the year under review.

100 Percent of Claims can be Reviewed

Bureau personnel stated they can review up to 100 percent of claims during their testing if they determine significant problems exist with a provider. Section 46.12.310 (5), ARM, states a provider who does not agree with the overpayment amount determined by statistical sampling may request the department conduct a 100 percent audit of the claims paid in the review period. If this audit shows an overpayment amount which is different from the overpayment amount determined by the sampling and extrapolation, the amount determined by the audit shall be used to assess the overpayment against the provider. The provider must pay the department's costs for such an audit unless the overpayment

amount determined by the 100 percent audit is at least 10 percent less than the overpayment amount determined by the statistical sample.

Copayment Calculations

Section 53-6-113 (5), MCA, states the department may provide by rule for a recipient to pay a portion of the services paid by the Montana Medicaid Program. The department adopted section 46.12.204, ARM, which states each recipient must pay to the provider $2 per service for home health and $.50 per service for durable medical equipment and medical supplies. The amount a recipient must pay is known as a copayment.

We reviewed Medicaid copayment amounts for home health services and medical supplies provided to recipients in our home health sample. We found the medical supply payment calculation does not determine the number of services provided when calculating the copayment amount. For example, a home health agency submitted a claim for services provided from November 3 through November 28, 1997, for a Medicaid recipient receiving home health services. The home health agency provided 79 units of service for medical supplies during this period and 12 home health visits. The copayment calculation by the department for medical supplies on this claim was $.50. The correct copayment amount based on the units of service which should have been deducted from the payment was $39.50.

Durable medical equipment and medical supplies can be provided by hospitals, physicians, home health agencies, and other Medicaid providers. The incorrect calculations are made on all durable medical and medical supply claims. As a result, payments to Medicaid providers of durable medical equipment and medical supplies have been incorrectly calculated. We determined 13 of 23 providers in our sample were overpaid $730.52 in January 1998 for home health medical supplies due to incorrect calculation of copayments. The Department of Public Health and Human Services has the responsibility to ensure copayment amounts are correctly calculated.

The Medicaid Management Information System calculates the copayment amount based on the claim line item, not on the units of

service as required by rule. Bureau staff were unaware the computer system was programmed in this manner.

We reviewed the Medicaid guide for recipients dated March 1998. The guide states recipients pay $2 per home health service and $.50 per item for supplies and equipment. This language does not agree with $.50 per service for medical supplies outlined in rule.

Bureau personnel did not refer to the rules when they issued the copayment information in the Medicaid guide and were not aware the rule stated the copayment would be calculated per service rather than per supply.

Recommendation #15

We recommend the department ensure the computer calculation and Medicaid publications for copayments are in compliance with section 46.12.204, ARM.

Department Response

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

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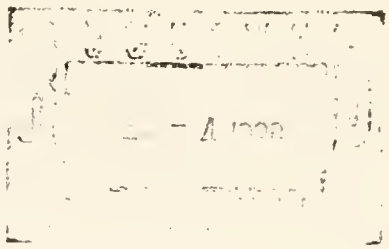

Mr Jim Pellegrini
Legislative Audit Division
Room 135, State Capitol
PO Box 201705
Helena, MT 59620-1705

Dear Jim:

The purpose of this letter is to respond to the recommendations contained in your division's performance audit of the Medicaid In-Home Services Programs administered by the Department of Public Health and Human Services. I'd like to commend you and your staff, especially Kris Wilkinson who did the bulk of the on site audit work, for the thorough and professional way in which this audit was performed. I am especially pleased that the audit recognizes the efforts of the Senior and Long Term Care Division (SLTCD) and Montana's in-home services provider and consumer network to both contain costs and maintain access to these critically necessary services.

As you will see from our responses, the SLTCD is in the process of implementing , or has already implemented, the majority of the audit recommendations. For a small number of the recommendations we have suggested alternative solutions that we believe would achieve the LAD's intended outcome, or agreed to test the recommendation in collaboration with the service provider and consumer networks.

Recommendation #1: We recommend the Community Services Bureau ensure home health care givers receive the program policies and procedures manual.

Department Response #1: Concur. The bureau has written a policy and procedure manual for home health services. It is currently in final revisions and scheduled to be released the week of December 14, 1998.

"An Equal Opportunity Employer"

Recommendation #2: We recommend the bureau develop rules, policies, and procedures outlining written plan of care requirements for:

- prescribing physicians,
- physician's signatures,
- dates, and
- verbal orders.

Department Response #2: Concur. This has been addressed in the policy and procedure manual.

Recommendation #3: We recommend the bureau:

A. Implement a compliance review process for home health providers.
B. Develop a provider education program for home health providers.

Department Response #3a: Concur. The bureau has contracted with the Mountain Pacific Quality Health Foundation to perform an annual compliance review. The first review will begin in March of 1999.

Department Response #3b: Concur. Training of home health providers will be accomplished through the policy and procedure manual, local training by Regional program officers and yearly provider training. The first yearly training will occur at the Community Services Conference in May of 1999.

Recommendation #4: We recommend the bureau consider a cost per unit of service reimbursement for home health payments.

Department Response #4: Concur. A provider work group will be established to review the feasibility of this type of reimbursement.

Recommendation #5 We recommend the Medicaid program implement alternative methods for delivering medication, including insulin, in a more cost-effective manner.

Department Response #5 Concur. The Community Services Bureau is working with staff in the pharmacy and durable medical equipment programs to look at alternative methods for delivering medications. By February, 1999 we will determine if there is a more cost effective method available to us that will also assure recipient safety.

Recommendation #6: We recommend the bureau and the Developmentally Disabled Program develop the most cost-effective method of delivering home health services to developmentally disabled recipients.

Department Response #6: Concur. The preliminary negotiations regarding this transfer have been completed. The Developmental Disability Program is in the process of designing a delivery system. This transfer will occur on July 1, 1999.

Recommendation #7: We recommend the bureau:

A. Require providers to submit claims for personal assistance services covering a week time period.
B. Establish a limit parameter on the MMIS which would identify billings submitted in excess of the weekly limits for personal assistance services.
C. Include a review of personal assistance claims to ensure providers do not bill for overlapping weeks during provider compliance reviews.

Department Response #7: Do not concur. We agree with the recommendation to establish a parameter limit, but not on a weekly basis. Establishing a viable weekly limit parameter would require costly computer system enhancements, reduce provider billing flexibility and add administrative requirements. As an alternative, the Community Services Bureau is currently researching the feasibility of setting a limit parameter on a monthly basis. Such a change would seem to accomplish the intent of the LAD recommendation without the need for costly computer system changes.

Recommendation #8: We recommend the bureau:

A. Provide Medicaid self-directed personal assistance service recipients clarification and education relating to amendments to plans of care if their condition changes.
B. Review both self-directed assistance services and home health services provided to recipients during compliance reviews.

Department Response #8a: Concur. The bureau will clarify and provide appropriate direction to providers regarding changes to the plan of care, via the policy manual. The providers will be held accountable for educating the consumers. This issue was addressed during the provider training of November 30, 1998.

Department Response #8b: Concur. The compliance review process will include a review of home health claims for individuals who elect to manage their health maintenance activities. This new standard will be initiated on July 1, 1999.

Recommendation #9: We recommend the bureau establish procedures to ensure the determination of whether a personal assistance provider met standards is based on the results of the charts reviewed.

Department Response #9: Concur. The bureau has revised the compliance review process to simplify the process. Part of this process focuses on correct measurement of each standard, and compliance on the whole. Training and a desk manual will be provided to the regional program officers regarding the review process. The work of the regional program officers will be reviewed to insure that outcomes are based on performance. The new process is complete, however new standards will not take effect until July 1, 1999.

Recommendation #10: We recommend the bureau:

A. Implement a home visit process which ensures regional program officers obtain the same information when conducting the reviews.
B. Ensure regional program officers retain records of home visits.
C. Periodically, review worksheets used in provider compliance reviews to determine if officers have followed bureau procedures relating to home visits.

Department Response #10: Concur. Effective January 1, 1999, regional program officers will receive a desk manual outlining the quality assurance process. This will include standardized questions to be asked during a home visit as well as direction regarding retention of records. Bureau program managers will periodically receive copies of worksheets to ensure that officers have followed bureau policy and procedures relating to home visits.

Recommendation #11: We recommend:

A. The legislature include language to allow the department to transfer appropriation authority between Medicaid programs.
B. The department appropriately transfer Medicaid funds into the waiver program to reduce nursing home expenditures.

Department Response #11: Concur. The department has discussed the issue of the transfer of appropriation authority between SLTCD Medicaid programs with the Legislative Fiscal Division(LFD) staff. We are working with the LFD to include a discussion of this issue on the Appropriation Sub-Committee on Human Services' agenda. We will develop criteria, policies and procedures for such transfers consistent with the direction from the 1999 Legislature.

Recommendation # 12: We recommend the bureau include home visit documentation in the compliance review process of home and community based waiver providers.

Department Response #12: Concur. Effective January 1, 1999, the Home and Community Based Services policy manual will have a revised section on the compliance review process. One of the new standards will be home visit documentation of individuals on the waiting list.

Recommendation # 13: We recommend the bureau implement rules for traumatic brain injury services provided under the Home and Community Based Waiver Services Program.

Department Response #13: Concur. Rules for traumatic brain injury services provided under the HCBS waiver program will be in place by July 1, 1999.

Recommendation #14: We recommend the bureau develop a statistical sampling approach to identify in-home service providers overpayment for the year under review.

Department Response #14: Concur. The department will convene a group of in-home service providers to develop and test the elements necessary to implement a statistical sampling procedure to recover overpayments to service providers. The staff of the SLTCD believe it is extremely important that the implementation of such a procedure occur only after a concentrated effort to

consult with, and educate, service providers in order to limit the potential for unintended consequences that might inadvertently restrict access to services in the future. In general the plan calls for testing a statistical sampling procedure in FY2000 and, assuming a positive outcome from the test, implementing such a procedure in FY2001.

Recommendation #15: We recommend the department ensure the computer calculation and Medicaid publications for co-payments are in compliance with section 46.12.204, ARM.

Department Response #15: Concur. The bureau will review all rules and documents regarding the home health co-payment to insure that they accurately represent the system co-payment calculation. A change to the rule will need to occur. All other department materials will be corrected as updates occur.

Thank you again for all of your assistance. The Medicaid In-House Services audit has been a positive experience which we intend to use as a tool to make good programs even better.

Sincerely,

Laurie Ekanger
Director